

DIVISION OF WORKERS COMPENSATION

KANSAS DEPARTMENT OF LABOR

800 SW JACKSON ST STE 600

TOPEKA KS 66612-1227

Phone(785) 296-3441

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E-mailwww.dol.ks.gov

DO NOT WRITE IN THIS SPACE

Docket Number (*if known*): _____

Phone Number: _____

Employee: _____

Social Security Number: _____

Employer: _____

Insurance Carrier: _____

**APPLICATION FOR
POST AWARD
MEDICAL**Employee applies for post award medical treatment authorized by the **decision entered on** _____
(*Date of Award or Order*)

1. State the nature of medical care sought: _____

2. The parties shall meet and confer prior to the scheduled hearing.

3. If the party is represented by an attorney, this form shall be signed by at least one attorney of record as required by K.S.A. 44-536a(a).

4. Are you interested in going through the Workers Compensation Mediation Process? ☐ Yes ☐ No

Applicant's Signature: _____

Address: _____

Signed this _____ day of _____, 20____

DO NOT WRITE IN THIS SPACE

Attorney's Signature: _____

Attorney's Printed Name: _____

Address: _____

Telephone Number: (_____) _____

Kansas Supreme Court Number: _____

Federal Privacy Act Disclosure Section 7(a)(2)(B)

The mandatory requirement that social security numbers be included on forms filed with the Division of Workers Compensation is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, since our regulations which require its disclosure were in existence before January 1, 1975. The number is used as a means of identifying all the various records in the Division of Workers Compensation pertaining to an individual.

The use of social security numbers is made necessary because of the large number of applicants who have similar names and birth dates, and whose identities can only be distinguished by the social security number.